TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-0407-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 97001, allowed amount of $104.26, multiplied at 200% reimbursement should be $208.52. Payment received was only $116.00, thus, according to these calculations; there is a pending payment in the amount of $92.52."

Amount in Dispute: $92.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is in the process of re-auditing to determine whether additional payment is due to the provider."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2016	97001, G8981, G8982	$92.52	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 96 – Non-covered charges(s)
   - P1 – (P12) Workers compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking an additional $92.52 for physical therapy services rendered in an outpatient hospital setting on June 27, 2016. The insurance carrier reduced disputed services with claim adjustment reason code P1 – "(P12) - workers compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.403 (f) states,

   > Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 200 percent; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   Review of the code 97001, finds a status indicator "A" denoting services paid under a fee schedule or payment system other than OPPS. The calculation of applicable fee based on applicable fee guideline is found below.

2. 28 Texas Administrative Code §134.403(h) states,

   > for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided.

   Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c) (1) which states in pertinent part,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor.)

   The Medicare Physician Fee Schedule amount for this code is $73.09. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the Division conversion factor of 56.82 yields a MAR of $115.91.

   Procedure code G8981 has status indicator E denoting excluded or non-covered codes not payable if submitted on an outpatient bill.

   Procedure code G8982 has status indicator E denoting excluded or non-covered codes not payable if submitted on an outpatient bill.

3. The total allowable reimbursement for the services in dispute is $115.91. The insurance carrier paid $116.00. No additional reimbursement recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 29, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.